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DISCUSSION PAPER

Extending the nursing role in Emergency Departments: Challenges for Australia

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Summary As nursing has developed as a profession there has been a continual evolution of the scope of practice in which nurses work. Emergency nursing practice is an example where recently there has been a rapid expansion in the nature and scope of practice. This change in practice has largely resulted from increasing public demand on emergency departments, medical and nursing shortages and governmental pressure to reduced emergency department waiting times and patient length of stay.

There have been a number of models worldwide in which the expansion of the Emergency Nurses role has occurred. Recently in New South Wales the Clinical Initiative Nurse role has been developed as an advanced practice role with the objective of initiating treatment based on advanced clinical assessment and to assist emergency departments to meet benchmarks and key performance indicators (KPIs). The scope of practice of this new role did not extend to that of a Nurse Practitioner who is able to discharge patients, prescribe medication and provide medical referral.

The variation in advance practice nursing roles in Australia and worldwide has contributed to confusion and uncertainty. The aim of this paper is to explore the various advanced practice roles that may be encountered in emergency nursing practice and examine some of the advantages and limitations to the implementation of these roles.

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Introduction

In many areas of clinical practice nurses are undertaking more specialised skills specific to their area of expertise. In particular, emergency nursing in Australia is rapidly

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developing and expanding in relation to scope and complexity of practice^{1,2} and there is a growing recognition of increased autonomy in decision-making and patient management.³

These changes in clinical practice are occurring worldwide and have resulted from the ever-increasing public and political demands, and the simultaneous shrinking of the medical and nursing workforce.^{4,5,6,7} Consequently emergency departments (EDs) have had to undertake initiatives to effectively meet government set key performance indicators and benchmarks that measure the individual institution's performance. The introduction of the Advanced Practice Nurse (APN) has been one cost effective strategy introduced into EDs to address key performance indicators, benchmarks and to also increase patient satisfaction. While nomenclature differs, for the purpose of clarity the term APN will refer to all nursing roles that extend beyond that expected of a registered nurse working within an ED. The purpose of this article is to introduce and recognise the Clinical Initiative Nurse (CIN), an APN role that has been implemented within New South Wales Emergency Departments.

Method

A literature search was undertaken by entering the keywords 'advanced practice, nurse practitioner, clinical nurse specialist, extended nursing roles, and emergency departments' into both the Cumulative Index for Nursing and Allied Health (CINAHL) and MEDLINE databases. Given the rapidly expanding nature of this role, information obtained from peer-reviewed journals was supplemented with information accessed from relevant government bodies and personal interviews. Papers were reviewed and included in this review if they contained relevant information/material regarding advanced practice nursing, nurse practitioner/emergency nurse practitioner and extending the nursing scope of practice. There is very little literature on APN roles other than the Nurse Practitioner (NP) or an equivalent role such as the Clinical Nurse Specialist (CNS) in United States of America (USA).⁸ A total of 26 relevant articles were identified and have been used to inform this paper, of which 9 were original research papers and 17 reviews of the literature.

Literature review

The global introduction of the APN role has contributed to the wide variability in nomenclature, role description, training, accreditation and education, both between and within countries. Within Australia the inconsistencies in characteristics of the APN role extend to institutions within specific area health services. This confusion is partly attributed to the speed in which these roles have been introduced.⁷ The absence of any consistency regarding APN has contributed to confusion and poor recognition regarding the scope of practice and role limitations. Furthermore, there is a lack of literature regarding APN roles⁸ that fall between the Registered Nurse and the Nurse Practitioner or an equivalent role such as the CNS in the USA. These extended roles are an integral component of the ED and serve to assist the individual

Table 1 Nomenclature associated with advanced practice nursing

Title	Abbreviation
Clinical Nurse Consultant	CNC
Clinical Nurse Specialist	CNS
Nurse Practitioner	NP
Emergency Nurse Practitioner	ENP
Clinical Initiative Nurse	CIN
Advanced Clinical Nurse	ACN
Advanced Emergency Nursing Practice	AENP
Clinical Nurse Educator	CNE

institutions ability to meet KPIs and benchmarks set by the government. Such measurements of performance that APN affect include patient length of stay and emergency waiting times.

Defining advanced practice nursing

Worldwide the nomenclature used to describe advanced practice nursing varies widely (Table 1) and provides a title which is ambiguous, offering no clear definition or role delineation.^{6,7,9,10} Oberle and Allen⁸ (p. 149) define advanced practice as 'the application of an extended range of practice, theoretical and research based, therapeutic to the phenomena experienced by patients within a specialised clinical area of the larger discipline of nursing'. Gardner et al.⁷ (p. 383) describe APN as 'those nursing roles that involve higher level knowledge and skills that enable clinicians to practise with autonomy and initiate nursing actions but do not include diagnostic and treatment decision-making'. These definitions are consistent with that of the Australian Nursing and Midwifery Council (ANMC)¹¹ (p. 5) who describe advanced practice as encompassing a high degree of knowledge, skill and experience that is applied within the nurse–patient relationship to achieve optimal outcomes through critical analysis, problem solving and accurate decision making.

The recognition and significance of these roles is often based on the individual institution's description of the role or job title and promotion of this role in the workplace. As a result, it is not uncommon to find wide variation in the scope of practice associated with various APN roles, even within the same state or area health service. This is supported in NSW by the Department of Health circular entitled *Guidelines for the hospital Seeking to Extend the Practice of Health Professional* which states:

'The Department takes the view that the extent of the practice of a health professional is implicit in the curriculum of their basic training. Any extension of practice beyond the skills included in the educational programme leading to registration as a health professional is a matter for an employer and/or the individual professional to determine, and limited only by statutory requirements. Both the individual and the employer need to satisfy themselves that the procedures as performed do not constitute a risk to the patient'.¹² (p. 2)

Table 2 Comparison of APN roles in NSW – Australia, United Kingdom and the United States of America

	NSW, Australia	United Kingdom	United States of America
Position	Emergency Nurse Practitioner	Emergency Nurse Practitioner	Emergency Nurse Practitioner
Education/experience	Postgraduate qualification relevant to speciality (Graduate Certificate, Graduate Diploma or Masters degree) plus 5000 h experience in advanced nursing practice ¹³	Masters degree or equivalent with degree/diploma supplemented with specialist training experience and short course ¹⁵	Masters degree
Role	Assessment and management of clients using nursing knowledge and skills and may include but is not limited to the direct referral of patients to other health care professionals, prescribing medication, and ordering diagnostic investigations ¹¹	Works autonomously in assessment and management of patient health/illness status and promotion of an effective nurse patient relationship, providing expert advice to patients, carers and colleagues. ¹⁶ Initiates investigation and treatment (including prescribing) as appropriate and with reference to hospital policy and interprets investigations, formulating a differential diagnosis. Manages and negotiates health care delivery systems including referral and discharge of patients ^{16–18}	Autonomous care provider delivering one-on-one holistic comprehensive patient care while also working in an interdisciplinary team, providing referral where necessary. Determines diagnostic, therapeutic and educational plans and ascertains a differential diagnosis. ^{20,21}
Position	Clinical Nurse Consultant (Grades 1–3)	Nurse Consultant-Band 8 (Consultant Nurse, Clinical Nurse Specialist, Lead Nurse ¹⁵) Nurse Advanced-Band 7 Lead Specialist, Clinical Nurse Specialist, Senior Specialist Nurse ¹⁹	Clinical Nurse Specialist
Education	Postgraduate qualification relevant to speciality (Graduate Certificate, Graduate Diploma or Masters degree) ¹⁴	Masters degree or equivalent with degree/diploma supplemented with specialist training experience and short course ¹⁵	Masters degree
Experience	CNC Grade 3 – seven years full-time equivalent (FTE) post registration experience with a minimum of five years FTE in specialist area. CNC Grade 2 – five years FTE post registration experience with a minimum of three years FTE in specialist area. CNC Grade 1 – five years FTE post registration experience. ¹⁴	Not specified	Not specified

Table 2 (Continued)

	NSW, Australia	United Kingdom	United States of America
Role	Provides a complex and expansive clinical consultancy service within a mixed clinical environment and/or across multiple service groups and/or populations and incorporating a range of modalities. Specific focus may include clinical supervision of peers, reviews of clinical practice, research, professional leadership, and education. ³⁵	Provides expert specialist advice to patients, carers and colleagues. Undertakes research in a specialist area. Provides education and training to other staff and students. Ensures the maintenance of clinical excellence. ¹⁵	Possesses advanced knowledge of both the basic science and the nursing science underpinning the speciality. ²³ Specific focus of role may vary and include consultant, expert clinician, education, case management and research. ^{22–23}
Position	Clinical Initiative Nurse Advanced Clinical Nurse, Advanced Emergency Nursing Practice		
Education	Locally developed education and must be competent in the Triage role		
Role	Patient care is the primary focus with focused clinical assessments and initiation of appropriate investigations occurring prior to the patient being seen by medical staff. Medications may be administered following standing orders. May provide early referral for patients known to specialty teams. ³⁷		

Consequently the criteria for accreditation, training and educational programs may differ dramatically and further contribute to wide variation in clinical standards and scope of practice. The individual nature of role titles, scope of practice, education and regulation has contributed significantly to confusion regarding advanced practice nursing in Australia and worldwide. [Table 2](#) aims to show comparisons between international titles, identifying equivalent roles in the USA, United Kingdom (UK) and Australia, New South Wales (NSW), while demonstrating the various titles used for similar role and job descriptions.

The context of advanced practice in the ED

Advanced practice within the context of Emergency Nursing practice requires APNs who are multifaceted and have their practice grounded in nursing, with aspects of their practice that extends beyond the responsibilities of the normal emergency nurse. The traditional boundaries of care delivery between the nursing and medical domains have blurred with the introduction of the APN. This blurring of the boundaries requires APNs to assume a role that involves a higher level of skill and knowledge. The APN role thus encompasses an extension of the work practice undertaken by many ED nurses and in some instances formally recognises care that has been provided by some senior ED nurses for many years with or without standing orders or protocols.

It is the utilisation and application of the higher level of knowledge and skills which are central components to an APN role. The use of standing orders and protocols doesn't affect the classification or definition of an APN role. Within EDs world-wide protocols and standing orders are independent to each institution, and enable the nurse to practice at an advanced level while complying with local legislation governing their practice. In part protocols and standing orders are used to meet medico-legal requirement, being utilised within some institutions for NPs and other APN roles.^{17,18} Tye¹⁸ believes that while clinical protocols are an inevitable consequence of an increasing litigation-conscious society, there is a danger that rigid over prescriptive policies may restrict professional judgement.

APN roles have been introduced world-wide as a strategy to alleviate the workload associated with increased public attendance and longer waiting times in EDs. Simultaneously there has been increased medical and nursing shortages which is associated with an extended length of stay in the ED and dissatisfaction of both staff and patients.^{4,6,7,10,18,24} The increased consumer demands for a faster and more efficient service has, in part, been an impetus for the development/utilisation of advanced practice nursing in the ED.^{6,25}

These consumer demands have led to a push from governing authorities to improve efficiency and efficacy. The implementations of benchmarks or key performance indicators have been enforced, requiring each hospital to meet pre-determined standards regarding waiting times and ED length of stay.^{2,4,25} For example, within the UK there is a four-hour length of stay benchmark for all patients who present to the ED. Similarly, NSW has an eight hour length of stay benchmark, and require that a pre-determined percentile of patients are seen within their Australian Triage Score (ATS) ([Table 3](#)). In many organisations the introduc-

tion of APN roles in the ED were established to assist hospitals in meeting these key performance indicators and benchmarks.¹⁰

The introduction of the APN role is seen as a strategy to provide fast effective management of patients within a defined scope of practice, while improving quality and cost effectiveness of patient care.⁶ The scope of practice, depending on the level of APN, is predetermined by the individual institution, or in collaboration between the nurse and ED Consultants. The implementation of APN has significantly contributed to a reduction in waiting times and ED length of stay, improved clientele and staff satisfaction, improved quality of care and patient outcomes and improved retention of senior nurses.^{4,6,27}

Advanced practice nursing – a historical and global perspective

The United States of America (USA)

Within the USA the concept of the APN dates back to 1954 when the first Clinical Nurse Specialist (CNS) role was defined. Subsequently, other advanced practice nursing positions have developed including Nurse Practitioner (NP), Certified Registered Nurse Anesthetist (CRNA) and Certified Nursing Midwife (CNM).^{5,22} Nurses reaching the level of CNS provide expert patient care and consultation at the patient's bedside while also being a leader and role model in nursing practice.^{20,21} The CNS is skilled in consultation, professional and patient education, advanced speciality clinical expertise, analysing health care systems and research to improve patient outcomes and the professional practice of nursing.^{21,22} Nurses practicing at this advanced level are required to hold at least a Masters degree in Nursing. Educational criteria and certification is nationally accepted, with nurses complying with individual state limitations on scope of practice.^{21,22} Cukr²⁰ states that the CNS also focuses on assessment and management of organisational system flaws, examines populations for utilisation review, develops critical care paths, and provides case management. The USA CNS is equivalent/comparable with the Australian Clinical Nurse Consultant and the UK Nurse Consultant (Grade 8) in regards to educational level, and standards of practice and nursing role as outlined in [Table 2](#).

Formal NP programs developed later in 1965 due to a shortage in primary care physician with the first NP being in the field of Paediatrics concentrating on a model for health promotion and disease prevention^{6,18,21,22}. Lynch²¹ explains that the introduction of the NP was also affected by societal needs and recognised untapped nursing potential. The role was originally developed to provide focused, one-on-one, direct primary health care services with ambulatory patients outside the hospital setting.²⁰ The role evolved, becoming a common fixture in other areas and sub specialities including acute care, primary health care, psychiatric/mental health, gerontology care, neonatal care, family health, community health and women's (obstetric/gynaecologic care) health speciality.^{18,20–22} Within the ED the NP provided a high quality, cost effective care to people seeking health care for non-urgent, urgent or emergent conditions.^{6,22} Boundaries of practice intersected with medicine, and scope of practice was a combination of both nursing and medical care with a holistic approach to treatment and care.

Table 3 Key Performance Indicator that are affected by ANP²⁶

Triage category	Brief description	Maximum recommended waiting time	Performance threshold (%)
1	Immediately life-threatening patients	2 min	100
2	Imminently life-threatening patients	10 min	80
3	Potentially life-threatening patients	30 min	75
4	Potentially serious patients	1 h	70
5	Less urgent patients	2 h	70

Performance threshold – the percentage of patients that need to be seen within their allocated triage time.

The USA was the first country to have the NP as a recognised ANP role. With an unorganised initiation of the NP, each individual hospital developed their program independently to meet the socio-cultural and political needs of their area and their clientele. The lack of clear guidelines or national scope of practice initially resulted in tremendous variations between facilities regarding the educational preparation and programs, state requirement of practice and recognition, level of experience and certifying bodies. Inconsistencies regarding the NP role^{22,28} resulted in the USA moving towards a nationally accepted educational standard of a Masters degree in an effort to provide clarity regarding the NP role, however scope of practice is still determined by individual state legislation. This action strived to achieve a national guideline regarding the role of the NP and is also consistent with the standard established for the CNS.^{22,28}

It is recognised that the CNS and NP role in the USA have differing focus, application and direction regarding health care yet both roles are considered equivalent in level of expertise, education and experience, with no one role predominating the other.²⁰ Since the 1980s there has been a widely held belief that the role of the NP and CNS overlap²⁹ sparking debate for a blended role. This has resulted in some educational programs that prepare nurses for both CNS and NP roles,²² however as Cukr²⁰ explains that while educational content may be similar, the focus and application of both roles remain distinct, and therefore the roles must remain distinct. This is reinforced by Brown²⁹ who believes that discussion pertaining to a blended APN role undermines their practice, and that we should embrace the different attributes that each APN role contributes to the evolving nursing profession.

The United Kingdom (UK)

In the UK the Emergency Nurse Practitioner (ENP) was a role established in EDs in the late 1980s.^{4,18} Tye and Ross¹⁷ and Tye¹⁸ define an ENP as an 'Accident and Emergency nurse who has sound nursing practice based in all aspects of Accident and Emergency nursing, with formal post-basic education in holistic assessment, physical diagnosis, in prescription of treatment and in the promotion of health'. Minor injury units are predominantly run by ENPs who are able to clinically assess patients, order investigations, discharge, refer and prescribe medication.¹⁸ The use of experienced ED registered nurses in this APN role was viewed as a cost effective initiative. The nurses utilised in this position have shown to be as clinically effective as their junior medical colleges.^{9,17,18} Davidson and Rogers³⁰ argued that ENPs in the UK perform equivalently to senior house offi-

cers with over five months experience. They believed that this trend would be transferable to the Australian context where Resident Medical Officers (RMOs) and interns rotate through the ED every 10 to 14 weeks and consequently have limited exposure to patients with minor injuries.³⁰

The ENP was seen as a complementary practitioner who work autonomously and collaboratively as situations demanded. The work practice undertaken by the ENP allowed medical officers to see and treat the more critically ill patients. Each individual ENP defined their scope of practice with the ED consultant support.^{9,31,32} A consequence of this was that the ENP role and scope of practice varied between hospitals and health areas/trusts. The introduction of ENP decreased waiting times and ED length of stay, both positive outcomes for the patient.^{18,28} However criteria and educational programs differ dramatically depending on the workplace and this has contributed to a lack of clarity and recognition of their role, unlike the consistency in the APN role that today is observed in the USA.^{18,24} It is widely recognised that educational preparation to an advanced level is an essential prerequisite for the ENP and there is a need for standardisation of education and training to ensure safe practice. With a move towards a Masters degree level (as accepted in the USA), equivalent experience, training and short course is also an acceptable educational standard within the UK contributing to some ENPs having no formal tertiary education. Tye¹⁸ recognises and confirms that there is a significant percentage of ENPs working without any formal education or have only attended 'in house' training programmes. It is argued that these ENPs still provide a safe and competent service³⁰ although there is little data to support this contention.

Advanced practice nursing in Australia – NSW as an exemplar

Similar to that experienced in the UK, Australian Emergency Departments are under considerable pressure to reduced ED patient waiting times and ED length of stay with a backdrop of increased public demand on the ED and both medical and nursing shortages. In 2002 the NSW Health Department organised an Emergency Nurse Advisory group that included Nursing Unit Managers and Clinical Nurse Consultant from various hospital throughout NSW. The aim of the group was to formulate a plan in response to an independent review of extended waiting times in NSW Emergency Departments. A review of metropolitan EDs resulted in state-wide recommendations to improve consumer satisfaction relating to increasing waiting times, including the allocation of a senior Emergency Nurse to the waiting room.¹⁰

In response to the review, the Emergency Advisor groups developed a draft scope of practice for advanced practice nursing which was flexible to meet the need of the individual organisation.¹⁰ The CIN role was established not only to provide education pertaining to health issues and information regarding the process of the ED but also to initiate treatment on waiting room patients through advanced clinical assessment.^{10,33} The CIN is an ED senior registered nurse who has undertaken advanced clinical training from a multidisciplinary approach to health care. Nursing, physiotherapist, and medical bodies impacted the role to enable these nurses to independently assess, treat and order investigation based on their advanced clinical assessment and training.

The Health Department funded the role for 16 h a day at 18 sites including Level 5 and 6 metropolitan hospitals and Level 4 rural hospitals in NSW.^{10,33} After the trial period it was up to the individual hospital and department to continue the role to meet the department's needs and assist them in meeting key performance indicators and benchmarks set by the government.

The CIN role was seen by some, as a stepping-stone towards the introduction, development and utilisation of the NP in the ED. The role was considered to provide a basic framework including advanced clinical assessment and judgment, X-ray ordering and interpretation, wound closure, back slab application and thorough documentation skills.^{10,34} Others however saw the role as a method in delaying the ENP because the APN role was not differentiated by remuneration and to some extent remained under the control of the medical profession. There was also concern that the role would become task orientated rather than focused on patient care² and that the nurse would be seen as a mini doctor or a medical substitute during times of doctor shortages.⁶

A generic role description and a proposed scope of practice were developed by the Advisory Group. A preliminary list³³ was created including assessment of:

1. Isolated limb injuries
2. Abdominal pain
3. Wound management
4. Minor head injuries
5. Gastroenteritis/oral dehydration – adult and paediatric
6. Fever
7. Minor per vaginal bleeding
8. Referral of known patients to inpatient teams and referral to OPD
9. Non-specific chest pain
10. URTI
11. Identification of patient groups which could be referred out of the ED to other service

This scope of practice had to be approved by the individual institution's hospital administration, who consequently develop their own CIN scope of practice. These predominantly included respiratory, abdominal, limb and wound assessment which were complimented by the ability to order radiological examinations, medications, and laboratory investigations to supplement clinical assessment. Skills such as venous cannulation, back slab application, arterial stab, and wound closure are also duties inherent within this APN role. This scope of practice was further refined based

on each institution's requirements resulting in further extension of the CIN's scope of practice from the initial proposed list, leading to hybrid/evolved CIN roles.

Developing an educational program, training, criteria for accreditation and standards of practice was also the responsibility of the individual institution¹⁸ resulting in a less rigorous standardised process and variability in practice quality. The selection criteria for inclusion into the program also differed, resulting in a great variation in experience and clinical knowledge, qualities necessary to perform as an ANP. In most EDs the role required the nurse to be working competently in triage,^{10,33} meaning they had extensive experience in emergency nursing and that they had met a predetermined criteria to commence work in this role. This process resulted in dramatic variations between each institution with an inevitable lack of clarity concurring the role. The differences made it impossible for the role to be easily transferable or recognised between each hospital.

As a result of the variation in educational preparation, clinical protocols, standing orders, and training the CIN role in various hospitals was poorly implemented and poorly utilised. This variation led to decreased medical support during role implementation and a loss of recognition of the role in some institutions. After the trial period and government funding had ceased, continuing support for the role was lost in some of these hospitals due to poor utilisation, implementation and recognition of the role.³⁴

With the varying differences in the advanced practice role, individual institutional programs thrived. Educational programs were created with nursing, medical and physiotherapist involvement, and support given by the ED Consultants. The programs were believed to not only develop the nurses' clinical judgment and assessment skills but also improved their documentation and ability to accurately refer patient to the ED medical officers.³⁴ For example, educational input from medical specialists focused on knowledge and skills related to advanced clinical assessment, pharmacology and the ordering and interpretation of distal limb x-rays while physiotherapists contributed to the programs, providing education concerning back-slab application and limb immobilisation. With programs being inclusive of ED team members, there was increased recognition of the benefits that may be gained through the successful development of an advanced practice nursing role within the ED.³⁴ The rigorous nature of the education provided for advanced practice development resulted in the programs gaining recognition of prior learning at a Masters degree level and the success of this program has led to its adoption at similar tertiary hospitals.^{34–36} Despite the uniformity of educational preparation within one health area for advanced practice in the ED, variability in the role and scope of practice exists in order to meet individual demands of the ED and hospital requirements.^{34,35}

Roles such as the CIN are yet to be defined by the Australian Nursing and Midwifery Council (ANMC). Unlike the ENP the CIN isn't a completely autonomous ANP role, as they do not diagnose, discharge, prescribe or refer patients to other medical specialities. However, like the benefits gained through other APN roles, the CIN has assisted hospitals in meeting benchmarks and KPIs, while also improving the satisfaction of the nurse and patient.³⁷ These inherent benefits that the CIN role brings to the institutions and departments

have led to the initiation of the role interstate, with South Australia (SA) utilising the APN role within their EDs.¹⁰

Lancaster-Bowie²⁵ supports the use of ED nurses in such APN roles asking "why push for NP when the role of the clinical nurse specialist hasn't been fully asserted or explored". The Clinical Nurse Specialist in NSW has been identified as a registered nurse that consistently and competently performs at an advance level within their specialty area. A Clinical Nurse Specialist is expected to perform serial functions including delivery of complex nursing care, clinical leadership, preceptor and role model, promotion of best clinical practice, protocols and policies, and a commitment to continuing education and professional development.³⁸ The NSW Department of Health has strived to use senior nursing staff (not limited to CNS) more efficiently with the development of the CIN roles and the more recent implementation of the "nurse seen time".

The Australian Nursing and Midwifery Council and advanced practice

In Australia a peak national nursing and midwifery organisation, The Australian Nursing and Midwifery Council (ANMC), was developed to ensure a national approach to nursing and midwifery regulation. In addition to developing professional standards for nursing, this organisation is also responsible for developing competency standards, including those for advanced practice nursing.

The advanced practice role identified by the ANMC is the NP is grounded in the nursing profession's values, knowledge, theories and practice. The scope of practice of the individual is also limited and determined by the context in which the NP is authorised to practice. The ANMC define a NP as a "registered nurse educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role. The NP role includes assessment and management of clients using nursing knowledge and skills and may include but is not limited to direct referral of patients to other health care professionals, prescribing medication and ordering diagnostic investigations".¹¹ (p. 1)

Various states in Australia have trialled different models of advanced practice nursing and enacted legislation regarding the implementation and accreditation of the role.³⁰ Some argue that the Australian nursing governing bodies are taking an over cautious and more complex course in implementing NPs.³⁰ Maurice and Byrnes³⁹ report that there is also substantial resistance to the NP role by the medical profession who fear nurses subsuming the medical role. This is supported by Martin and Considine,⁴⁰ they believe that the traditional domains of other health professionals are being threatened with ENP practice encroaching across conventional professional boundaries.

The NP specific for the Emergency Department, the Emergency Nurse Practitioner (ENP) is a relatively new advanced practice nursing role within Australia, and is yet to be recognised as a vital role in the provision of emergency care.^{6,39} The utilisation of ENP has been an effective initiative in rural and remote areas of Australian.⁵ The utilisation and mass introduction of the ENP in metropolitan hospitals will be a consequence of consumer demand and political pressure, similar to that experienced in the UK upon a back drop of medical shortage as experienced in the USA.⁶ While it is well

accepted that ENPs provide fast, cost effective autonomous management of patients within their scope of practice,⁶ the benefits of decreased waiting times, improved staff and patient satisfaction have also been achieved through the introduction of other APN roles, like the CIN in New South Wales. However, Considine et al.²⁶ believe that the ENPs would further decrease waiting times, length of stays and patient satisfaction as they would be able to see, treat, discharge and refer patients appropriately depending on their individual circumstances, a concept that is echoed by Maurice and Byrnes³⁹ who state that ENPs enable the facility to provide faster access to health care in overcrowded and busy EDs.

O'Connell, the first authorised NP in Australia, believes that while the initial focus has been on rural and remote areas there are many areas within the urban health care environment that need a NP, particularly the ED.⁶ This is supported by Considine et al.²⁶ who state that the ENP role would "extend current advanced emergency nursing practice, and may include prescribing medication, initiating diagnostic imaging and pathology testing, approving absence from work certificates, referring to specialist and admitting and discharging patients". It is the greater autonomy in practice that separates the ENP from other APN roles.

There is a general positive attitude towards the introduction of ENP in Australia, however there is confusion regarding their scope of practice, accreditation and education.⁴⁰ There is no set scope of practice for NPs in Australia, as it is dependent on the area in which they work and the clientele they treat.

Education and training

Tertiary institutions such as University of Technology, Sydney (UTS) and the University of South Australia have implemented various ENP programs. Individual metropolitan hospitals throughout Australia have done likewise but their programs are not linked to a formal tertiary qualification. With these programs the trainee ENP works directly under the ED Staff Specialist while completing the educational requirements and clinical experience to successfully complete the NP state accreditation process. The success of these programs, and others like it will have dramatic impact on the introduction of the ENP role within other ED.

Conclusion

Internationally there is mass confusion regarding APN roles. Many hospitals and organisations share titles such as CNS, yet their scope of practice, job description, training, education and accreditation vary dramatically. With the haphazard development of the NP role within the UK and USA, a National standards and scope of practice regarding these APN roles was initially non-existent. The absence of these standards of practice together with no initial regulatory body resulted in the great variations between education, accreditation and training through the individual country, however these issues are being addressed with the introduction of governing bodies, and the international recognition of NP as a valued ANP role. This situation is a common occurrence with the introduction of new APN roles, as

their introduction is area and institution specific. Without a regulatory body and clear standards of practice, having international recognition regarding APN is practically impossible.

With increasing waiting time, public presentation, and political pressure to meet key performance indicators and benchmarks, EDs have introduced ANP roles to meet the departmental needs. These APN roles recognise and utilise the experience, expertise, skills and clinical knowledge of senior emergency nurses. The CIN scope of practice is between that of a Registered Nurse and NP or an equivalent role such as the USA CNS or Australian CNC. While there is a plethora of resources that discuss NP and the USA CNS, there is very little material that recognises APN role such as the CIN in NSW.

To completely evaluate the extent of the emergency nurses' role in Australian EDs as an APN, a demographic study is required. A demographic study would provide valuable knowledge on the various skills performed by APN across the country and the educational preparation involved. This would provide a clearer understanding of APN scope of practice in Australia, and assist in gaining national and international recognition for the various roles. Having clarity regarding the Australia APN recognises the accomplishments of nurses in Australia acting in these roles, and the clinical development of the nursing profession in this country.

Competing interests

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